PARTNERS
FOR HEALTH

# Your 2019 Eligibility & Enrollment Guide

## State and Higher Education Employees

Tennessee State Group Insurance Program

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# INTRODUCTION

## Overview

This guide will help you understand your insurance options and the coverage rules for state and higher education employees. There is a separate guide for retirement insurance.

Benefits Administration, within the Department of Finance and Administration, manages the State Group Insurance Program. The State Plan includes employees of state government and higher education.

If you are eligible, you may enroll in health, dental, vision, life and disability insurance. Flexible spending accounts (FSA) are also available.

## For More Information

Your agency benefits coordinator is your primary contact. This person is usually located in your human resources office. He/she is available to answer benefit questions and can provide you with forms and insurance booklets.

You can also find information like brochures and handbooks, plan documents, summaries of benefits and coverage and sample certificates of coverage on the Benefits Administration website, https://www.tn.gov/partnersforhealth.html.

## Authority

The State Insurance Committee is authorized to determine the premiums, benefits package, funding method, administrative procedures, eligibility provisions and rules relating to the State Plan. You will be given written notice of changes.

### State Insurance Committee

- Commissioner of Finance and Administration (Chairman)
- State Treasurer
- Comptroller of the Treasury
- Commissioner of Commerce and Insurance
- Commissioner of Human Resources
- Two members elected by popular vote of general state employees
- One higher education member selected under procedure established by the Tennessee Higher Education Commission
- One member from the Tennessee State Employees Association selected by its Board of Directors
- Chairs of the House and Senate Finance, Ways and Means Committee

Certain state and federal laws and regulations, which may be amended or the subject of court rulings, apply to the group insurance program. These laws, regulations and court rulings shall control over any inconsistent language in this guide.

### Individuals Not Eligible for Coverage as a Dependent

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Foster children
- Children over age 26 (unless they meet qualifications for incapacitation/disability)
- Live-in companions who are not legally married to the employee

## Enrollment and Effective Date of Coverage

As a new employee, your eligibility date is your hire date. You must complete enrollment within 31 days after your hire date. Coverage starts on the first day of the month after you complete one full calendar month of employment, except for voluntary term life insurance. Voluntary term life insurance will become effective after you have completed three full calendar months of employment.

If you are a part-time employee who has completed one full calendar month of employment and you gain full-time status, your coverage will start the first day of the month after gaining full-time status. Application must be made within 31 calendar days of the date of the status change, but you should submit your enrollment request as soon as possible to avoid the possibility of double premium deductions.

You must be in a positive pay status on the day your coverage begins. If you do not enroll in health coverage by the end of your enrollment period you must wait for the annual enrollment period, unless you have a qualifying event during the year. Refer to the special enrollment provisions section of this guide for more information.

**Positive Pay Status — Being paid even if you are not actually performing the normal duties of your job. This is related to any type of approved leave with pay.**

A dependent's coverage starts on the same date as yours unless newly acquired. Application to add a newly acquired dependent must be submitted within 60 days of the acquire date. Family coverage based on enrolling newly acquired dependent children due to birth, adoption or legal custody must begin on the first day of the month in which the event occurred and the children shall be eligible for coverage on the date they were acquired. Coverage for an adopted child begins when the child has been adopted or has been placed for adoption. If enrolled in single coverage and adding a newly-acquired spouse, you may choose to begin family coverage on the first day of the month in which your spouse was acquired or the first day of the following month. Depending on the date you choose, your newly acquired spouse will be covered beginning with the acquire date (date of marriage) or the first day of the following month.

Insurance cards will be mailed to you three to four weeks after your application is processed. You may call the insurance carrier to ask for extra cards or print a temporary card from the carrier's website.

## Choosing a Premium Level (Tier)

There are four premium levels for health, dental and vision coverage to choose from.

- Employee Only
- Employee + Child(ren)
- Employee + Spouse
- Employee + Spouse + Child(ren)

**Family Coverage — Coverage other than employee only is considered family coverage.**

If you enroll as a family in the second, third or fourth premium level, all of you must enroll in the same health, dental and vision options. However, if you are married to an employee who is also a member of the state, local education or local government plan, you can each enroll in employee only coverage if you are not covering dependent children. If you have children, one of you can choose employee only and the other can choose employee + child(ren). Then you can each choose your own benefit option and carrier.

## Updating Personal Information

State employees can update information, such as home address, in Edison or by contacting their agency human resources offices. Higher education employees can update information in Edison, contact their agency benefits coordinators or call the Benefits Administration service center to request an address or email address change. All employees who contact Benefits Administration (BA) will be required to provide their Social Security number or Edison ID, date of birth, previous address and confirm authorization of the change before BA can update the information. **It is your responsibility to keep your address, phone number, and email address current with your employer.**

## Annual Enrollment Period

During the fall of each year, benefit information is mailed to you. Review this information carefully to make the best decisions for you and your family members. The enrollment period gives you another chance to enroll in health, dental, vision, voluntary accidental death coverage, voluntary term life and disability insurance coverage. You can also make changes to your existing coverage, like increasing or decreasing voluntary term life insurance, transferring between health, dental, disability and vision options and cancelling insurance.

Most changes you request start the following January 1. However, voluntary term life and disability insurance may start January 1, February 1 or March 1. This is due to the review of medical history by the insurance carriers to determine your qualification for coverage.

Benefit enrollments remain in effect for a full plan year (January 1 through December 31). However, you may cancel disability and voluntary term life coverage at any time. **You may not cancel other coverage outside of the enrollment period unless eligibility is lost or there is a qualifying change or event.** For more information, see the section on cancelling coverage in this guide.

## Cancelling Coverage

Outside of the annual enrollment period, you can only cancel coverage (other than disability and voluntary term life insurance) for yourself and/or your covered dependents, IF:

- You lose eligibility for the State Group Insurance Program (e.g., changing from full-time to part-time)
- You experience a special qualifying event, family status change or other qualifying event as approved by Benefits Administration

You must notify your agency benefits coordinator of any event that causes you or your dependents to become ineligible for coverage. You must repay any claims paid in error. Refunds for any premium overpayments are limited to three months from the date notice is received.

When cancelled for loss of eligibility, coverage ends the last day of the month eligibility is lost. For example, coverage for adopted children ends when the legal obligation ends. Insurance continued for a disabled dependent child ends when he/she is no longer disabled or at the end of the 31-day period after any requested proof is not given.

**Divorce** — If you request to terminate coverage of a dependent spouse while a divorce case is pending, such termination will be subject to laws and court orders related to the divorce or legal separation. This includes the requirements of Tennessee Code Annotated Section 34-4-106 and the requirement that you provide notice of termination of health insurance to your covered dependent spouse under Tennessee Code Annotated Section 56-7-2366. As the employee, it is your responsibility to make sure that any request to terminate your dependent spouse is consistent with those legal requirements.

You must make the request within 60 days of acquiring the new dependent. You must also submit proof, as listed on the enrollment application, to show:

- The date of the birth
- The date of placement for adoption
- The date of marriage

The above events are ONLY subject to special enrollment IF you want to use the event to enroll yourself or you already have coverage and want to add other previously eligible dependents at the same time as the new dependent. If you already have coverage and only want to add a newly acquired dependent, this is treated as a regular enrollment change.

Options for coverage start dates due to the events above are:

- Day on which the event occurred if enrollment is due to birth, adoption or placement for adoption
- Day on which the event occurred or the first day of the next month if enrollment is due to marriage

### Other events allow enrollment based on a loss of coverage under another plan:

- Death of a spouse or ex-spouse
- Divorce
- Legal separation
- Loss of eligibility (does not include loss due to failure to pay premiums or termination of coverage for cause)
- Termination of spouse's or ex-spouse's employment
- Employer ends total premium support to the spouse's, ex-spouse's or dependent's insurance coverage (not partial)
- Spouse's or ex-spouse's work hours reduced
- Spouse maintaining coverage where lifetime maximum has been met
- Loss of TennCare (does not include loss due to non-payment of premiums)

Applications for the above events must be made within 60 days of the loss of the insurance coverage.

### You must submit proof as required to show ALL of the following:

- A qualifying event has occurred
- You and/or your dependents were covered under another group health plan at the time of the event
- You and/or your dependents may not continue coverage under the other plan

If enrolling due to loss of coverage under another plan, options for coverage start dates are:

- The day after the loss of other coverage, or
- The first day of the month following loss of other coverage

### Important Reminders

- If enrolling dependents who qualify under the special enrollment provisions, you may choose to change to another carrier or health option, if eligible
- If you or your dependents had COBRA continuation coverage under another plan and coverage has been exhausted, enrollment requirements will be waived if application is received within 60 days of the loss of coverage
- Loss of eligibility does not include a loss due to failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause

If restored before returning to the employer's active payroll, you must pay 100 percent of the total premium. In all instances, you must pay the entire premium for the month.

Reinstatement of coverage is not automatic. Military personnel must re-apply within 90 days from the end of leave.

## Leave Due to a Work-related Injury

If you have a work-related injury or illness, contact your agency benefits coordinator about how this will affect your insurance. You must keep insurance premiums current until you receive a notice of lost-time pay from the Division of Claims Administration. You will receive a refund for any health insurance payments you make once you receive notice.

If approved for lost-time pay, only the premium for health insurance is paid by your agency. You must pay the premium for any voluntary coverage on a monthly basis. You are responsible for 100 percent of the premium when lost-time pay ends if you do not have any paid leave.

**Lost-time Pay — Payments received due to lost time (without pay) caused by an approved work-related injury. Lost-time pay is approved by the Department of Treasury, Division of Claims.**

All benefits paid by the plan for work-related injury or illness claims will be recovered. This means that you are required to repay all claims paid related to a work-related injury.

## Termination of Employment

Your insurance coverages end when your agency terminates your employment and the information is sent to Benefits Administration.

- State employees: If your last day worked is the last day of the month, your coverage will end on the last day of the following month. If your last day worked is any date other than the last day of the month, your coverage will end on the last day of the current month. Disability insurance will end after your last day worked.
- Higher education employees: Coverage will end on the last day of the month following the month you terminate employment. Disability insurance will end after your last day worked.

A COBRA notice to continue health, dental and/or vision coverage (depending upon your enrollment as an active employee) will be mailed to you. Disability and life insurance conversion notices will also be mailed, if applicable.

In the event that your spouse is also insured as a head of contract under either the state, local education or local government plan, you have the option to transfer to your spouse's contract as a dependent. Application must be made within one full calendar month of your termination of employment.

## Continuing Coverage through COBRA

You may be able to continue health, dental and/or vision insurance coverage under the Consolidated Omnibus Budget Reconciliation Act. This is a federal law known as COBRA. This law allows employees and dependents whose insurance would end to continue the same benefits for specific periods of time. Persons may continue health, dental and/or vision insurance if:

- Coverage is lost due to a qualifying event (refer to the COBRA brochure on our website for a list of events)
- You are not insured under another group health plan as an employee or dependent

Benefits Administration will send a COBRA packet to you. It will be sent to the address on file within 7-10 days after your coverage ends. Make sure your correct home address is on file with your agency benefits coordinator. You have 60 days from the date coverage ends or the date of the COBRA notice, whichever is later, to return your application to Benefits Administration. Coverage will be restored immediately if premiums are sent with the application. If you do not receive a letter within 30 days after your insurance ends, you should contact Benefits Administration.

# AVAILABLE BENEFITS

## Health Insurance

You have a choice of three health insurance options:

- Premier Preferred Provider Organization (PPO)
- Standard PPO
- Consumer-driven Health Plan (CDHP)/Health Savings Account (HSA)

You also have a choice of three insurance carrier networks:

- BlueCross BlueShield Network S
- Cigna LocalPlus Network
- Cigna Open Access Plus Network (monthly surcharge applies)

With each health insurance option, you can see any doctor you want. However, each carrier network has a list of doctors, hospitals and other healthcare providers that you are encouraged to use. The providers in the network have agreed to take lower fees for their services. Your cost is higher if you use out-of-network providers.

### Each health insurance option:

- Provides the **same comprehensive health insurance coverage** (although medical policies for specific services may vary between carriers)
- Includes in-person and state-sponsored Telehealth medical services
- Offers the **same provider networks**
- Covers **in-network preventive care** (like annual well visits and routine screenings) **at no cost to you**
- Covers **maintenance** prescription drugs without having to first meet a deductible
- Has a deductible
- Has out-of-pocket maximums to limit your costs

There are some differences between the PPOs and the CDHP.

### With the PPOs

- You pay a higher monthly premium but have a lower deductible
- You pay fixed copays for doctor office visits and prescription drugs without first having to meet your deductible

### With the CDHP/HSA

- You pay a lower monthly premium but have a higher deductible
- You pay the full discounted network cost for **ALL** healthcare expenses, except for in-network preventive care and certain maintenance drugs, until you meet your deductible
- You have a tax free health savings account (HSA) which can be used to cover your qualified medical expenses, including your deductible

### CDHP/HSA

If you enroll in this option, the state will deposit $250 for employee only coverage or $500 for family coverage into your health savings account (HSA). If your coverage effective date is September 2 through the end of the year, you will not receive the state contribution towards your HSA in 2019.

There are lower out-of-pocket costs on a large group of maintenance drugs. To pay the lower price for these certain medications, you must use the special, less costly Retail-90 network (pharmacy or mail order) and fill a 90-day supply of your medication. The maintenance tier list includes certain medications for high blood pressure, high cholesterol, coronary artery disease, congestive heart failure, depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

Eligible members will be able to receive certain low-dose statins in-network at zero cost share. These medications are primarily used to treat high cholesterol. No high dose or brand statins are included.

Any and all compound medications (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound medications require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Members won't have to pay for some specific medications used to treat opioid dependency.

## Basic Features of the Health Options

| | PPOs (Premier & Standard) | CDHP/HSA |
|---|---|---|
| **Covered Services** | Each option covers the same set of services | |
| **Preventive Care** — routine screenings and preventive care | Covered at 100% (no deductible) | |
| **Employee Contribution** — premium | Higher than the CDHP | Lower than the PPOs |
| **Deductible** — the dollar amount of covered services you must pay each calendar year before the plan begins reimbursement | Lower than the CDHP | Higher than the PPOs |
| **Physician Office Visits** — includes specialists and behavioral health and substance use services | You pay fixed copays without having to first meet your deductible | You pay the discounted network cost until the deductible is met, then you pay coinsurance |
| **Non Office Visit Medical Services** — hospital, surgical, therapy, ambulance, advanced x-rays | You pay the discounted network cost until the deductible is met, then you pay coinsurance | |
| **Prescription Drugs** | You pay fixed copays without having to first meet your deductible | You pay for the medication at the discounted network cost until your deductible is met — then you pay coinsurance until you meet the out-of-pocket maximum |
| **Out-of-Pocket Maximum** — The most you pay for covered services; once you reach the out-of-pocket maximum, the plan pays 100% | Higher than the CDHP | Lower than the PPOs |
| **Health Savings Account** | None | The state will contribute $250 for single coverage and $500 for family coverage to help offset the deductible — your contributions are pre-tax |

| CDHP/HSA | |
|---|---|
| IN-NETWORK [1] | OUT-OF-NETWORK [1] |
| | |
| No charge | 40% coinsurance |
| | |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | N/A |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | |
| | |
| 20% coinsurance | 40% coinsurance plus amount exceeding MAC |
| 20% coinsurance | N/A - no network |
| 10% coinsurance without first having to meet deductible | N/A - no network |
| 20% coinsurance | N/A - no network |

## 2019 Monthly Premiums for Health

| ALL REGIONS | | | | |
|---|---|---|---|---|
| | BCBST | CIGNA LOCALPLUS | CIGNA OPEN ACCESS | EMPLOYER SHARE |
| **PREMIER PPO** | | | | |
| Employee Only | $136 | $136 | $176 | $543 |
| Employee + Child(ren) | $204 | $204 | $244 | $814 |
| Employee + Spouse | $284 | $284 | $364 | $1,140 |
| Employee + Spouse + Child(ren) | $352 | $352 | $432 | $1,411 |
| **STANDARD PPO** | | | | |
| Employee Only | $92 | $92 | $132 | $543 |
| Employee + Child(ren) | $139 | $139 | $179 | $814 |
| Employee + Spouse | $195 | $195 | $275 | $1,140 |
| Employee + Spouse + Child(ren) | $241 | $241 | $321 | $1,411 |
| **CDHP/HSA** | | | | |
| Employee Only | $60 | $60 | $100 | $543 |
| Employee + Child(ren) | $89 | $89 | $129 | $814 |
| Employee + Spouse | $125 | $125 | $205 | $1,140 |
| Employee + Spouse + Child(ren) | $154 | $154 | $234 | $1,411 |

See footnotes on page 17.

| CDHP/HSA | |
|---|---|
| IN-NETWORK [1] | OUT-OF-NETWORK [1] |
| | |
| No charge | 40% coinsurance |
| | |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | 40% coinsurance |
| 20% coinsurance | |
| 20% coinsurance | |
| 20% coinsurance | 40% coinsurance |
| See separate sections in the Member Handbook for details. | |
| | |
| $1,500 | $3,000 |
| $3,000 | $6,000 |
| $3,000 | $6,000 |
| $3,000 | $6,000 |
| | |
| $2,500 | $4,500 |
| $5,000 | $9,000 |
| $5,000 | $9,000 |
| $5,000 | $9,000 |
| | |
| State contribution to HSA: $250 for employee only; $500 for employee+child(ren), employee+spouse and employee+spouse+child(ren) coverage | |

## Using Edison ESS

Edison is the State of Tennessee's Enterprise Resource Planning (ERP) system. When using Employee Self Service (ESS) in Edison to add/make changes to benefits, Internet Explorer 11 is the preferred browsewr. You may not be able to enroll if you use another browser, mobile device or a tablet.

## Passwords

- For higher education employees, if you are using the Edison system for the first time or are having trouble logging in, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps or call the Benefits Administration service center.
- For state employees, if you have trouble logging in to Edison, go to the Edison home page and click on 1st Time Login/Password Reset and follow the steps to reset your password or call the Edison help desk at 866.376.0104.

Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge (MAC) will not be counted. **For PPO Plans,** no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. **For CDHP Plan,** the deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied. See the "Out of Pocket Maximums" section in the Member Handbook for more details. For CDHP Plan, coinsurance is after deductible is met unless otherwise noted.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

[3] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[4] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

[5] For PPO Plans, the deductible DOES NOT apply. For CDHP, the dedutible DOES apply as required.

## 2019 Monthly Premiums for Long Term Disability (LTD)

| LTD: EMPLOYEE'S AGE (PER $100 OF COVERED MONTHLY SALARY) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefit %/ Elimination Period** | **Under 30** | **30-34** | **35-39** | **40-44** | **45-49** | **50-54** | **55-59** | **60-64** | **65-69** | **70+** |
| Option 1 60%/90 days | $.20 | $.20 | $.40 | $.59 | $.75 | $.92 | $1.10 | $1.46 | $.97 | $.97 |
| Option 2 60%/180 days | $.16 | $.16 | $.31 | $.46 | $.59 | $.72 | $.86 | $1.14 | $.76 | $.76 |
| Option 3 63%/90 days | $.24 | $.24 | $.49 | $.72 | $.91 | $1.12 | $1.34 | $1.78 | $1.18 | $1.18 |
| Option 4 63%/180 days | $.19 | $.19 | $.39 | $.57 | $.72 | $.89 | $1.06 | $1.41 | $.94 | $.94 |

## Long Term Disability Options

| | Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|---|---|---|
| **Eligibility** | All employees working not less than 30 hours/week or seasonal employees hired prior to July 1, 2015 with 24 months of service and certified by their appointing authority to work at least 1,450 hours per fiscal year (July-June), or is deemed eligible by applicable federal law, state law, or action of the State Insurance Committee. | | | |
| **% of Gross Annual Base Salary Paid Monthly** | 60% of salary paid monthly | | 63% of salary paid monthly | |
| **Maximum Monthly Benefit** | Up to $7,500 per month (covers annual salary of $150,000) | | Up to $10,000 per month (covers annual salary of $190,476.24) | |
| **Minimum Monthly Benefit** | Greater of 10% of benefit or $100 per month | | | |
| **Elimination (Waiting) Period** | 90 calendar days | 180 calendar days | 90 calendar days | 180 calendar days |
| **Own Occupation** | 24 months | 24 months | 36 months | 36 months |
| **Duration of Benefit** | Social Security Normal Retirement Age | | | |
| **Evidence of Insurability (EOI)** | Guaranteed Issue (no health questions asked) for 2018 Annual Enrollment and New Hires who enroll within 31 days of eligibility date. EOI will be required for late enrollees and 2018 plan participants who choose a higher plan of benefit during the 2019 Annual Enrollment Period. | | | |
| **Pre-existing Condition** | Three months prior to effective date and 12 months from effective date | | | |

## Dental Insurance

Voluntary dental coverage is available to all state and higher education employees and their dependents. You must pay 100 percent of the premium if you elect this coverage. Two dental insurance plans are available—a prepaid plan and a dental preferred provider organization (DPPO) plan.

In the prepaid plan, you must select from a specific group of dentists. Under the DPPO plan, you may visit the dentist of your choice; however, members get maximum savings when visiting a network provider. Both dental options have specific rules for benefits such as exams and major procedures and have a four-tier premium structure just like health insurance.

You can enroll in dental coverage as a new employee or during the annual enrollment period. You may also enroll if you have a special qualifying event. You do not have to be enrolled in health coverage to be eligible for dental insurance.

### Prepaid Plan (Cigna)

- Must select and use a general dentist from the prepaid dental plan list for each covered family member — the network is a select number of dentists in Cigna Dental HMO (DHMO)
- Copays for dental treatments, including adult and child orthodontia for up to 24 months
- No claim forms
- Preexisting conditions are covered if they are listed in the Patient Charge Schedule, unless treatment starts before coverage begins
- Referrals to specialists are required
- No maximum benefit levels
- No deductibles
- No charge for oral exams, routine semiannual cleanings, most x-rays and fluoride treatments; however, an office visit copay will apply

### DPPO Plan (MetLife)

- Use any dentist, but you receive maximum benefits when visiting an in-network MetLife DPPO provider — the network is PDP
- $1,500 calendar year benefit maximum per person
- Deductible applies for basic and major dental care. Coinsurance for basic, major, orthodontic and out-of-network covered services
- You or your dentist will file claims for covered services
- Referrals to specialists are not required
- Benefits for covered services paid at the lesser of the dentist charge or the scheduled amount
- Some services require waiting periods of up to one year and limitations and exclusions apply
- Lifetime benefit maximum of $1,250 for orthodontia

## 2019 Monthly Premiums for Dental

| | CIGNA PREPAID PLAN | METLIFE DPPO PLAN |
|---|---|---|
| ACTIVE MEMBERS | | |
| Employee Only | $13.44 | $23.64 |
| Employee + Child(ren) | $27.91 | $54.36 |
| Employee + Spouse | $23.83 | $44.72 |
| Employee + Spouse + Child(ren) | $32.76 | $87.50 |

## Vision Insurance

Voluntary vision coverage is available to all state and higher education employees and dependents. You must pay 100 percent of the premium for this coverage. Two options are available: a Basic and an Expanded plan. Both plans offer:

- Routine eye exam once every calendar year
- Frames once every two calendar years
- Choice of eyeglasses or contact lenses once every calendar year
- Discount on LASIK/Refractive surgery

What you pay for services depends on the plan you choose. With the Basic plan, you pay a discounted rate or the plan pays a fixed-dollar allowance for services and materials. The Expanded plan provides services with a combination of copays, allowances and discounted rates. See the benefit chart on the following page to compare benefits in both plans.

The Basic and Expanded plans are both administered by Davis Vision. You will receive the maximum benefit when visiting a provider in their network. However, out-of-network benefits are also available.

### General Limitations and Exclusions

The following services are not covered under the vision plan:

- Treatment of injury or illness covered by workers' compensation or employer's liability laws
- Cosmetic surgery and procedures
- Services received without cost from any federal, state or local agency
- Charges by any hospital or other surgical or treatment facility and any additional fees charged for treatment in any such facility
- Services by a vision provider beyond the scope of his/her license
- Vision services for which the patient incurs no charge
- Vision services where charges exceed the amount that would be collected if no vision coverage existed

**Note:** If you receive vision services and materials that exceed the covered benefit, you will be responsible for paying the difference for the actual services and materials you receive.

**Davis Vision offers some value-added services which include:**

- Zero copay for single vision, bifocal, trifocal or lenticular lenses purchased at an in-network location
- Free pair of eyeglass frames from "The Exclusive Collection" under the in-network Expanded plan
- Free pair of "Fashion Selection" eyeglass frames from "The Exclusive Collection" under the in-network Basic plan
- Free pair of frames at Visionworks retail locations
- 40% discount off retail under the in-network Expanded plan and 30% discount off retail under the in-network Basic plan for an additional pair of eyeglasses, except at Walmart, Sam's Club or Costco locations
- 20% discount off retail cost of additional pair of conventional or disposable contact lenses under in-network Expanded plan
- One year warranty for breakage of most eyeglasses
- 30% to 60% off the cost of brand name hearing aids through EPIC Hearing Healthcare

## 219 Monthly Premiums for Vision

| | BASIC PLAN | EXPANDED PLAN |
|---|---|---|
| ACTIVE MEMBERS | | |
| Employee Only | $3.07 | $5.56 |
| Employee + Child(ren) | $6.13 | $11.12 |
| Employee + Spouse | $5.82 | $10.57 |
| Employee + Spouse + Child(ren) | $9.01 | $16.35 |

## Employee Assistance Program

Your Employee Assistance Program (EAP) is administered by Optum. It is available to all benefits-eligible employees and eligible dependents, as well as COBRA participants. Receive five EAP visits, per situation, per year at no cost to you.

Master's level specialists are available around the clock to assist with stress, legal, financial, mediation and work/life services. They can even help you find a network provider, a plumber who works nights, find services for your elderly parents, theater tickets, all-night pharmacies and so much more.

Optum knows you are busy, and they want to provide you with information when you need it. All you have to do is call 855.Here4TN (855.437.3486).

### Here4TN Behavioral Health and Substance Use Services

Whether you are dealing with a mental health or substance use condition, support is available through your behavioral health coverage. Behavioral health benefits are only available to those enrolled in medical insurance. Your enrolled dependents can use these benefits too.

Optum is your behavioral healthcare vendor. To receive maximum benefit coverage, participants must use a network provider. For assistance finding a network provider, call 855.HERE4TN (855.437.3486).

In addition to office visits, this benefit includes virtual visits. What does that mean? You can meet with a provider through private, secure video conferencing. Virtual visits allows you to get the care you need sooner and in the privacy of your home. The cost for virtual visits is the same as an office visit. To get started, go to Here4TN.com, scroll down, select provider search, and click on virtual visits to find a provider licensed in Tennessee, or call 855.Here4TN (855.437.3486) for assistance. Learn more about your behavioral health benefit by visiting Here4TN.com.

## ParTNers for Health Wellness Program

Starting January 1, 2019, state and higher education members and enrolled spouses will have access to a new wellness program. ActiveHealth Management will be your wellness program vendor. They will help you achieve your health goals through special programs and resources, and you can also get rewarded for taking action by earning cash incentives that will be deposited through payroll*.

Here's how it works:

Regardless of the health plan you choose, you and your enrolled spouse can choose from a variety of programs and activities to earn up to $250 each. That could be up to $500 annually. You must first complete a health assessment before you can earn the cash incentives. Note: new hires/new plan members, your earnings may be limited depending on your hire date.

There will be a variety of programs to choose from. They include:

- Biometric screenings
- Weight management program (brand new program)
- Tobacco cessation program
- Wellness counseling (diet, stress, exercise, etc.)
- Disease management program
- Group coaching for lifestyle and disease management programs
- Online resources (challenges, health education library with videos and articles)

For more information, go to www.tn.gov/partnersforhealth, under Other Benefits and Wellness.

*Members must be in a positive pay status to receive an incentive. The cash incentive for both the employee and eligible spouse will be deposited directly into the member's paycheck and will be taxed.

# Life Insurance

## Basic Group Term Life and Accidental Death & Dismemberment Insurance

The state provides, at no cost to you, $20,000 of basic term life insurance and $40,000 of basic accidental death & dismemberment (AD&D) coverage. If you enroll in health insurance as the head of contract, the amount of coverage increases as your salary increases, with premiums for coverage above $20,000/$40,000 deducted from your paycheck. The maximum amount of coverage is $50,000 for basic term life and $100,000 for accidental death & dismemberment. The face amount of coverage declines at ages above 65. If you do not enroll in health coverage, the amount of coverage does not increase regardless of salary.

Changes in coverage based upon age or salary take effect on the first day of October based on your age and salary as of September 1.

Eligible dependents (spouse and children) enrolled in health insurance are covered for $3,000 of basic dependent term life coverage and for basic AD&D. The amount of AD&D coverage is based on salary and family composition. If you do not enroll in health coverage, your dependents are not eligible for basic term life or basic AD&D coverage.

## Voluntary Accidental Death & Dismemberment

You and your dependents (spouse and children) may enroll in this coverage at low group rates, no questions asked. It is in addition to the basic AD&D coverage and you must pay a premium. Benefits are paid for dismemberment if the loss occurs within 180 days of the accident, as long as you or your dependent is covered on the date of the accident and meet the criteria. Coverage amounts are based on salary and age. The maximum benefit for you is $60,000.

## Voluntary Term Life Insurance

You and your dependents (spouse and children) may enroll in this coverage whether or not you enroll in health coverage. A premium is required. For employee guaranteed issue coverage, you must enroll during the first 31 calendar days of employment with the state. The effective date of coverage is the first of the month after you have completed three full calendar months of employment. If you do not enroll when first eligible, you can apply for coverage during the annual enrollment period by answering health questions.

You may select up to five times your annual base salary (subject to a maximum of $500,000) if you apply when first eligible, without answering health questions. You may apply for up to seven times your annual base salary (subject to a maximum of $500,000), but evidence of good health is required. The minimum coverage level is $5,000.

Your spouse may apply for $5,000, $10,000 or $15,000 of term life insurance at any age. Spouses below age 55 may apply for increments of $5,000, subject to an overall maximum of $30,000. Spouses must be performing normal duties of a healthy person of similar age and gender and not have been hospitalized, advised to seek medical treatment or received disability benefits within six months prior to the application to enroll date for coverage to be issued without answering any additional health questions. A spouse who does not meet the previous criteria may apply for coverage by answering specific health questions which the insurance company will use to decide if coverage will be allowed. You do not have to enroll in this coverage in order for your spouse to participate.

Children may be covered under either a $5,000 or a $10,000 term rider. The rider is added to either your certificate or your spouse's certificate, but not both. These amounts will cover all eligible dependent children who meet the dependent definition. Coverage for children is guaranteed issue.

The voluntary term life insurance provides a death benefit and the premiums increase with age each January 1st. It also offers an advance benefit rider, which allows payment of the life insurance proceeds if an insured encounters a terminal illness with a life expectancy of no more than 12 months.

# OTHER INFORMATION

## Coordination of Benefits

If you are covered under more than one insurance plan, the plans will coordinate benefits together and pay up to 100 percent of the eligible charges. At no time should payments exceed 100 percent of the eligible charges.

As an active employee, your health insurance coverage is generally considered primary for you. However, if you have other health coverage as the head of contract, the oldest plan is your primary coverage. If covered under a retiree plan and an active plan, the active plan will always be primary. If your spouse has coverage through his/her employer, that coverage would be primary for your spouse and secondary for you.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. This coordination of benefits can be superseded if a court orders a divorced parent to provide primary health insurance coverage. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.

From time to time, carriers will send letters to members asking for other coverage information. This is necessary because it is not uncommon for other coverage information to change. This helps ensure accurate claims payment. In addition to sending a letter, the carriers may also attempt to gather this information when members call in. You must respond to the carrier's request for information, even if you just need to report that you have no other coverage.

If you do not respond to requests for other coverage information, your claims may be pended or held for payment. When claims are pended, it does not mean that coverage has been terminated or that the claims have been denied. However, claims will be denied if the requested information is not received by the deadline. Once the carrier gets the requested information, they will update the information regarding other coverage, and claims that were pended or denied will be released or adjusted for payment.

## Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover the following:

- Any payments made as a result of injury or illness caused by the action or fault of another person
- A lawsuit settlement that results in payments from a third party or insurer of a third party
- Any payments made due to a workplace injury or illness

These payments would include payments made by worker's compensation insurance, automobile insurance or homeowners insurance whether you or another party secured the coverage.

You must assist in this process and should not settle any claim without written consent from the Benefits Administration subrogation section. If you do not respond to requests for information or do not agree to pay the plan back for any money received for medical expenses the plan has already paid for, you may be subject to collections activity.

## On-the-job Illness or Injury

Work-related illnesses or injuries are not covered under the plan. The plan will not cover claims related to a work-related accident or illness regardless of the status of a worker's compensation claim or other circumstances.

## Appealing to the Insurance Company

To start an appeal (sometimes called a grievance), call the toll-free member service number on your insurance card. You may file a formal request for an appeal or member grievance by completing a form or as otherwise instructed.

The insurance company will process internal levels of appeal — Level I and Level II appeals. Decision letters will be mailed to you at each level. These letters will tell you if you have further appeal options (including independent external review) and if so, how to pursue those options and how long you have to do so.

## Pursuing Further Action

In cases where internal and external appeal procedures have been completed, decision letters will notify you of the option to pursue further action through litigation.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल करे।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

توجه: اگر هب زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 866-576-0029 (TTY: 1-800-848-0298) مهارف می باشد. با تماس بگیرید.

## The Notice of Privacy Practice

Your health record contains personal information about you and your health. This information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). The Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), including Privacy and Security Rules. The notice also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices. The Notice of Privacy Practice is located on the Benefits Administration website at https://www.tn.gov/partnersforhealth.html. You may also request the notice in writing by emailing benefits.privacy@tn.gov.

## Prescription Drug Coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. By law, we are required to inform plan members of this coverage yearly. You can find a copy of the required notice regarding your options on the Benefits Administration website.

If you are actively employed or a pre-65 retiree enrolled in health coverage, you have pharmacy benefits. You do not need to enroll in Medicare prescription drug coverage regardless of your age. Once your retiree group health coverage terminates due to becoming Medicare eligible you may want to enroll in Medicare prescription drug coverage if you need pharmacy benefits.

## Summary of Benefits and Coverage

As required by law, the State of Tennessee Group Health Plan has created a Summary of Benefits and Coverage (SBC) for the state-sponsored health plans. The summaries describe your 2019 health coverage options. You can view it online at https://www.tn.gov/partnersforhealth/summary-of-benefits-and-coverage.html or request that we send you a paper copy free of charge. To ask for a paper copy, call Benefits Administration at 855.809.0071.

## Plan Document

The information contained in this guide provides a detailed overview of the benefits available to you through the State of Tennessee. More information is contained within the formal plan documents. If there is any discrepancy between the information in this guide and the formal plan documents, the plan documents will govern in all cases. You can find a copy on the Benefits Administration website at https://www.tn.gov/partnersforhealth/publications.html.

## Other Publications

In addition to the documents mentioned above, the Benefits Administration website contains many other important publications at https://www.tn.gov/partnersforhealth/publications.html, including, but not limited to, a sample basic term life/basic AD&D certificate, sample voluntary AD&D certificate, brochures and handbooks for medical, pharmacy, dental, vision, life insurance and the plan document, brochure and handbook for The Tennessee Plan (Supplemental Medical Insurance for Retirees with Medicare).